Pharmacy Safety Project

Correlation between administration of the AHRQ SOPS and adaptation of medication safety systems in New York State hospitals

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Track: SOPS Data Analysis

Session: Special Data Analysis Topics: Use of SOPS, Negatively

Worded Items, and Trending

Date & Time: April 21, 2010, 8:00 am

Track Number: SOPS T4 – S1

Background

Health Research, Incorporated (HRI) is a not-for-profit corporation affiliated with the New York State Department of Health (DOH) and the Roswell Park Cancer Institute (RPCI). HRI's mission is to assist DOH and RPCI to effectively evaluate, solicit, and administer external financial support for projects.

NYS Attorney General's Office awarded HRI funding as a result of an out of court settlement to promote studies, research and public education on pharmaceutical safety.

Three parts to overall project

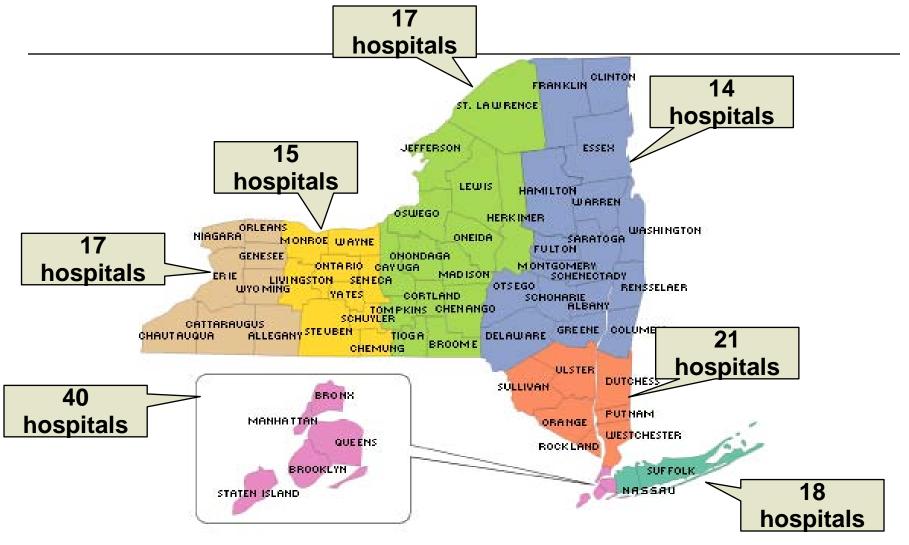
- NYPORTS-New York Patient Occurrence Reporting and Tracking System
- Assessment of current hospital pharmacy safety practices in NYS
- 3. Organizational level funding to support adaptation of pharmacy safety systems particularly aligned with the OHITT strategy

Collaborative

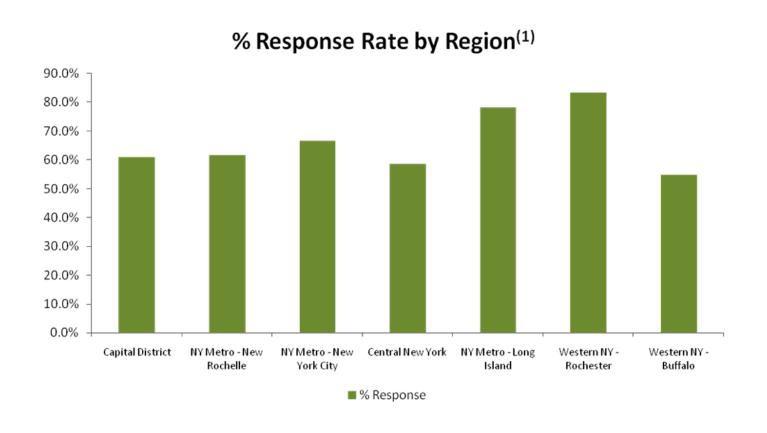
- Two part web based survey of current pharmacy safety practices and use of NYPORTS incident reporting system
- On September 8, 2010 survey was released to NYS hospitals soliciting information on their pharmaceutical safety programs

189 Pharmacy Directors; 149 responses = 78.8% response rate

Pharmacy Safety Survey Responses



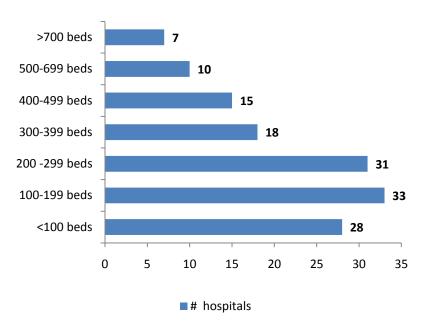
Within region response rates



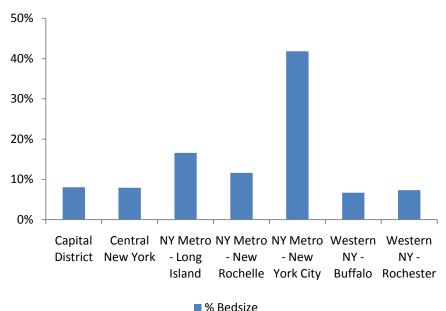
Hospital size and teaching status

Total # of Hospitals	Teaching	Non-Teaching
149	52.1%	47.9%

Bedsize Distribution



Breakdown of bedsize by Region

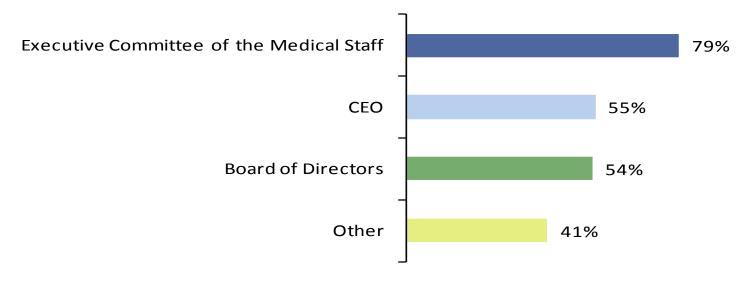


Medication Safety Practices

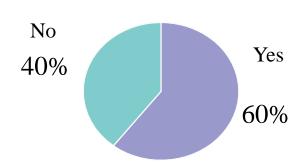
B.Technology C.Prescribing A.Policies and Controls E. Pharmacy D. Transmission **Dispensing Transcription**

Culture - Medication safety plan, and executive involvement

Medication safety issues get reported to:



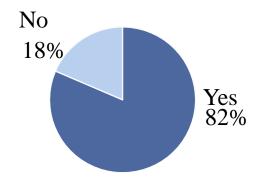
Do you have a specific and detailed medication safety plan?



Culture – SOPS and near misses

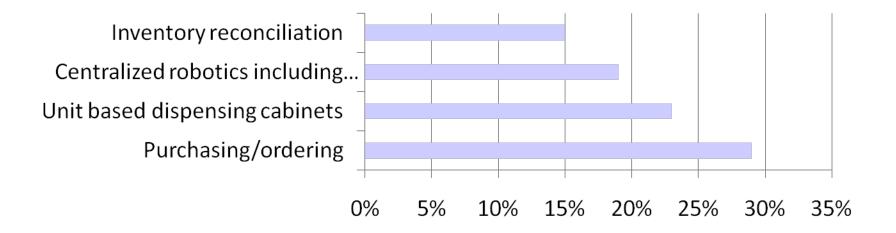
- □ 48 % of respondents have administered SOPS
 - 77% have an action plan in place based on results

Does your hospital collect and report categories (near misses) or C" from the National Coordinating Council Medication Error Reporting and Prevention (NCCMERP)?



Bar Coding

□ 49% have Bar Coding within the pharmacy

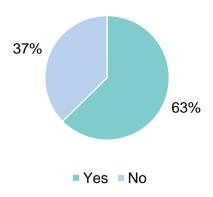


- 22% have Bedside Bar Coding Administration
 - 46% plan to implement in the next 12 months

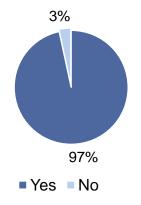
Smart Pumps

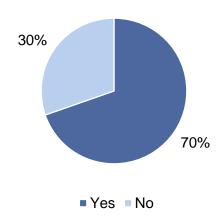
Do you use smart pumps?

Nursing is permitted to override the library and use the pump without the library:

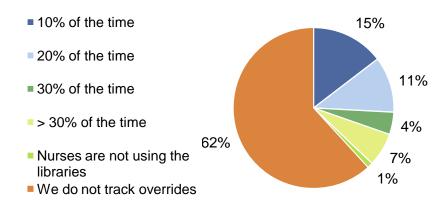


The use of smart pumps prevents adverse events through a library and the libraries are turned on.



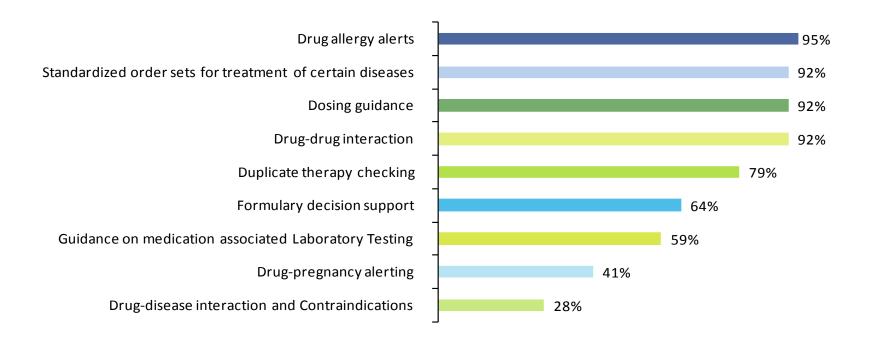


Nursing overrides the pump libraries:

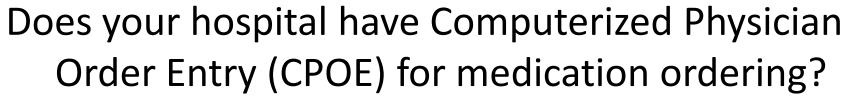


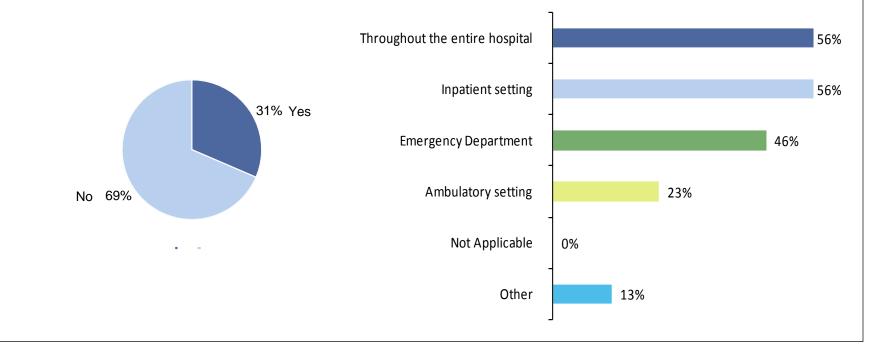
Physician decision support tools

Please select all decision support tools that are readily available to physicians for computerized order entry in electronic medical record



CPOE

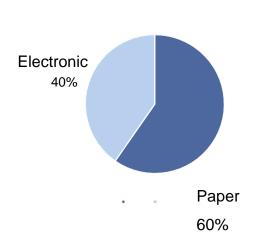


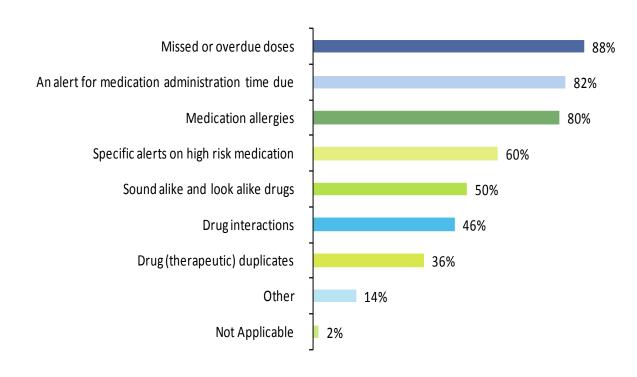


Electronic Medication Administration Record

Our Medication Administration Records are:

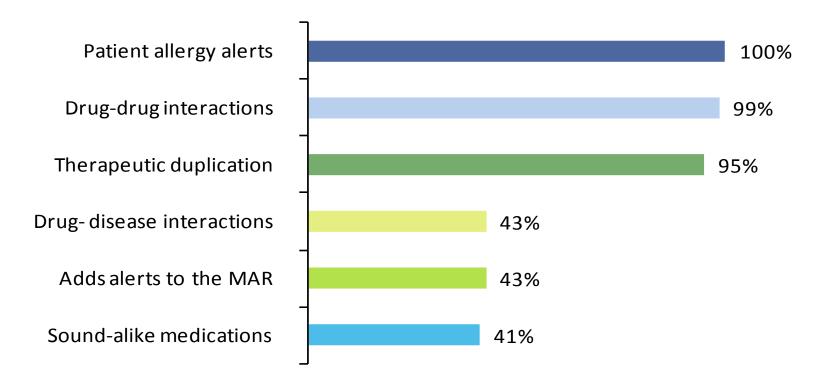
Alert functions in eMAR





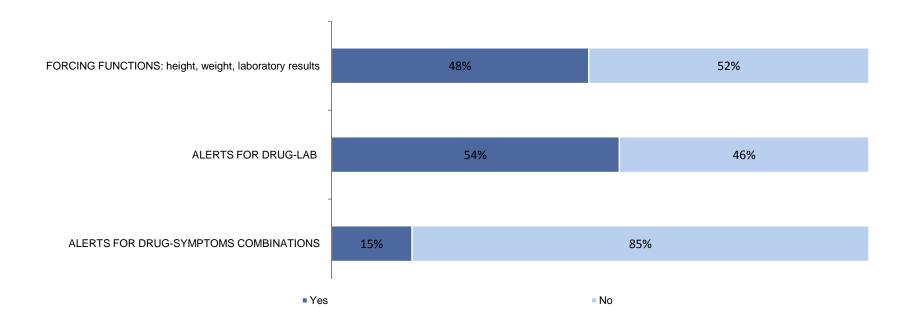
Pharmacy computer system alerts

Types of Alerts:



And more alerts

Pharmacy Computer System Alerts



Pharmacy Safety Systems

Culture • AHRQ SOPS survey • Executive leadership involvement • Medication Safety plan • Near misses Actions Technology • eMAR • CPOE • Bar Coding • Smart Pumps Culture Technology

Actions

- · External reporting
- Corrective actions
- Pharmacy systems and forcing functions
- Tracking overrides

Patient Safety Culture

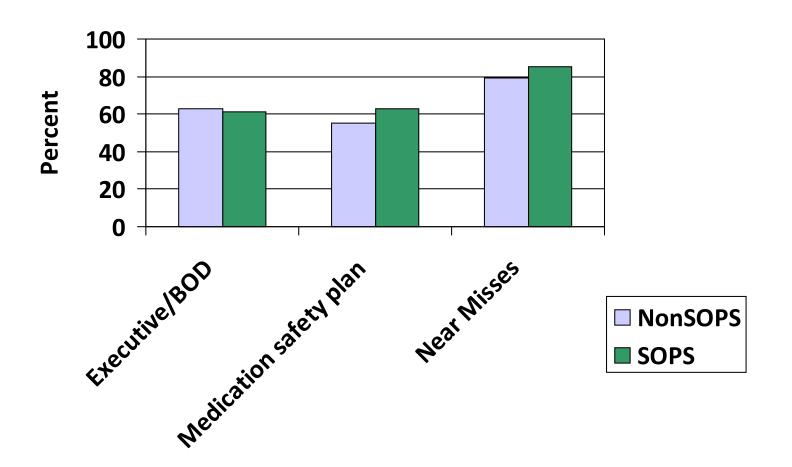
- Organizations with a positive patient safety culture are characterized by
- communications founded on mutual trust,
- shared perceptions of the importance of safety, and
- confidence in the efficacy of preventive measures.

[&]quot;Hospital Survey on Patient Safety Culture" AHRQ Publication No.04-0041

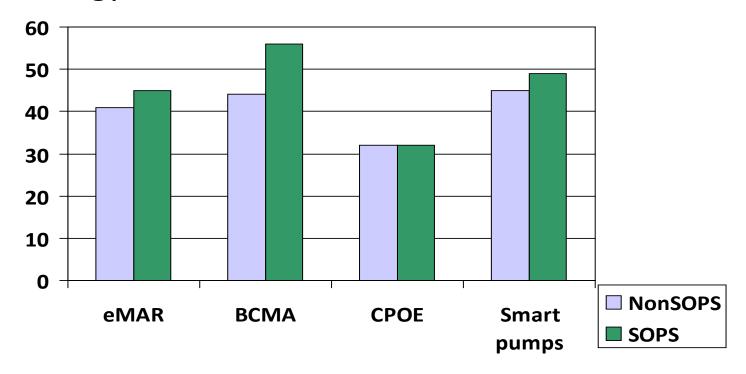
Why SOPS?

- Assume organizations that have administered AHRQ SOPS are interested in promoting a positive patient safety culture
- Should there be a correlation?
- Are hospitals that have administered the survey further along the continuum?

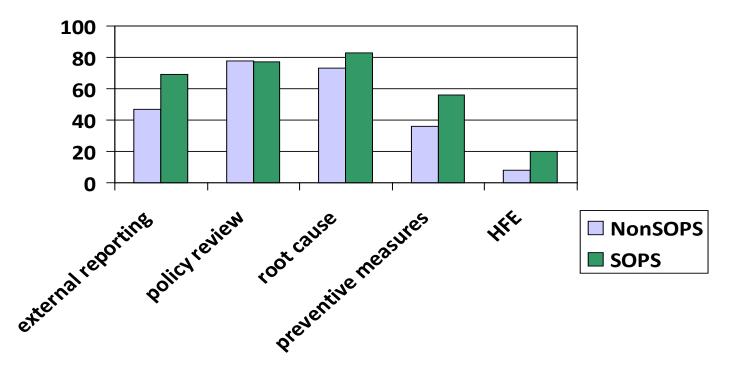
Culture measures



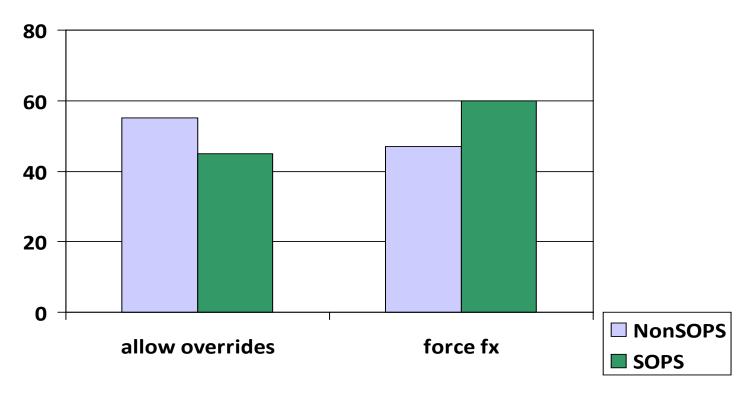
Technology measures



Action measures in response to error



Action measures



On what measures do SOPS users differ?

- □ Culture
- □ Actions
- □ Technology
- □ Any of the Above

Acknowledgements

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Health Research Inc.

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